

Home Health

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Home Health Billing Information

The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

Provider Qualifications

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program client
- Submit claims for payment to the Colorado Medical Assistance Program

In order to become a Medicaid Home Health Provider, an agency **must**:

- Hold a current and active Class A Home Care License issued by the State of Colorado;
- Obtain Medicare certification and/or deemed status an accepted Home Health Accreditation entity: Joint Commission (JC), Community Health Accreditation Program (CHAP) or the Accreditation Commission for Health Care, Inc (ACHC);
- Be enrolled as a Medicare provider; and
- Be in good standing with the Colorado Department of Health Care Policy and Financing, Colorado Department of Public Health and Environment (CDPHE), and Medicare.

After obtaining licensure and certification as a Class A Home Care Agencies, an applicant must submit a completed provider enrollment packet to become a Colorado Medical Assistance Program eligible provider. Providers will find enrollment information on the Provider Services Enrollment section of the Department's website (colorado.gov/hcpf). Enrollment documents must be completed and mailed to:

Xerox State Healthcare
Provider Enrollment
PO Box 1100
Denver, CO 80201-1100

Home Health Agencies must comply with rules and regulations for Medicaid Home Health, including but not limited to the Home Health Benefit Coverage Standard and 10 C.C.R. 2505-10 § 8.520-8.529.

All Home Health services provided are subject to post-payment review for medical necessity and regulation compliance.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 30, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following manuals:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com)
- Companion Guides for the 837P, 837I, or 837D (in the Provider Services [Specifications](#) section of the Department's website.
- Web Portal User Guide (via within the portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the [Colorado Medical Assistance Program Secure Web Portal](#) (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).

The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for "dialing up" when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or PCR containing information related to submitted claims. The Web Portal provides access to the following reports through the File and Report Service (FRS):

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)

- Managed Care Reports such as Primary Care Physician Rosters
- Prior Authorization Letters
- Users may also inquire about information generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. Other inquiry options include:
 - Eligibility Inquiry (interactive and batch)
 - Claim Status Inquiry
 - PAR Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal. Access the Web Portal at colorado.gov/hcpf → [Secured Site](#). For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services [Specifications](#) section.

Batch Electronic Claims Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Department's fiscal agent.

Any entity sending electronic transactions through the fiscal agent's Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic transactions, including claims. An enrollment package may be obtained by contacting the Department's fiscal agent or by downloading it from the Provider Services [EDI Support](#) section.

The X12N 837 Professional (837P), Institutional (837I), or Dental (837D) transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the Medicaid Management Information System (MMIS), the interchange will reject and a TA1 along with the data will be forwarded to the State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to EDI Gateway. Assistance from EDI business analysts' is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.

The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, EDI Gateway requires providers to submit all X12N test transactions to Edifecs prior to submitting them to EDI Gateway.

The EDIFECs service is free to providers to certify X12N readiness. Edifecs offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to edifecs.com.

General Prior Authorization Requirements

Acute Home Health PARs

Acute Home Health Services do not need to be prior authorized. However, if the client is enrolled in a Medicaid Managed Care Organization (MCO), such as Denver Health, Rocky Mountain Health Plans or Colorado Access Health Plan, please contact the [MCO](#) directly to determine the health plan's acute Home Health prior authorization requirements.

Long-Term Home Health (LTHH) PARs

All LTHH Services shall be submitted to the Department's authorizing agency as soon as possible, but no more than 10 business days from the start date of the LTHH PAR. Authorizing agency information is listed in Appendices C and D of the Appendices located in the Provider Services [Billing Manuals](#) section of the Department's website. The Home Health PAR form must be completed and reviewed by the Department's authorizing agency before services can be billed.

Long-Term Home Health PARs that are not received by the authorizing agency in a timely manner shall have the PAR start date amended to 10 business days prior to the date the PAR was originally scheduled to start.

A PAR is not considered complete until the authorizing agency reviews all information necessary to review the request. All LTHH PAR submissions must include:

- The complete and current plan of care using the HCFA-485 or other document that is identical in content which must include a clear listing of:
 - Client's diagnoses that will be addressed by Home Health, using V-codes whenever appropriate;
 - The specific frequency and expected duration of the visits for each discipline ordered; and
 - The duties/treatments/tasks to be performed by each discipline during each visit.
- All other supporting documentation to support your request including physician's orders, treatment plans, nursing summaries, nurse aide assignment sheets, medications listing, etc; and
- Any other documentation deemed necessary by the Department or its authorizing agency.

The plan of care must be created by a registered nurse employed with the Home Health Agency or when appropriate by a physical, occupational or speech therapist. The plan of care must be signed by the client's attending physician prior to submitting the final claim for a certification period. For additional information on Medicaid plan of care requirements refer to the Home Health Services Benefit Coverage Standard referenced in 10 C.C.R 2505-10 § 8.522 – Covered Services

Please submit the appropriate completed PAR via:

- Pediatric clients - eQSuite®
- Adult clients - the Department's [designated form](#)

Pediatric PARs

All pediatric LTHH PARs must be submitted via [eQSuite®](#).

[ColoradoPAR Program](#)

Prior Authorization (PAR) Vendor for the Colorado Medical Assistance Program

Provider PAR Request Line: 888-801-9355

PAR Fax Line: 866-940-4288

Adult PARs

All adult LTHH PARs must be submitted on the Department's designated Long Term Home Health PAR form. The form is available in the Provider Services [Forms](#) section of the Department's website. Instructions for completing the PAR form are included in this manual.

The authorizing agency reviews all completed PARs and approves or denies, by individual line item, each requested service listed on the PAR. PAR status inquiries can be made through the File and Report System (FRS) in the Web Portal and PAR determinations are included on PAR letters sent to both the provider and the client. **Read the determination carefully as some line items may be approved and others denied. Do not render or bill for services until the PAR has been processed.**

The claim must contain the PAR number for payment.

Approval of a PAR does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Prior authorization only assures that the services requested are considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

If the PAR is denied, providers should direct inquiries to the authorizing agency who reviewed the PAR.

Do not submit claims before the PAR has been reviewed and approved unless submission is necessary to meet timely filing requirements. Refer to the [Department Program Rules - Code of Colorado Regulations](#) located in Boards & Committees in the Medical Services Board section of the Department's website for required attachments.

PAR Revisions

If the number of approved units needs to be amended, the provider must submit a request for a PAR revision **prior** to the PAR end date. Changes requested after a PAR is expired will not be made by the Department or the authorizing agency.

Note: When a PAR is revised, the number on the original PAR must be used on the claim. (Do not use the PAR number assigned to the revision when completing a claim. Use the original PAR number.)

Pediatric Long-Term Home Health PAR revisions should be completed in eQSuite®. Adult LTHH PAR revisions must be made on the Department's designated form and submitted to the authorizing agency for review. Complete the Revision section of the PAR and include the PAR number that you need to be revised.

Note: The number of units should equal more/less the number of units planned for use during the PAR period. The number of units being requested needs to be added to the original number of units approved and include all services that were approved on the original PAR.

Change of Provider Revisions

When a client in long-term home health changes providers during an active PAR certification, the receiving Home Health Providers shall complete a [Change of Provider Form](#) in order to transfer the client's care from the previous provider to the receiving agency.

Once the receiving agency completes the Change of Provider form, the form must include the client's signature to indicate that the client is in agreement with the change of provider request.

The completed Change of Provider form must accompany a new Home Health PAR from the receiving agency.

The agency must submit the Change of Provider form along with a new PAR to the authorizing agency. The new PAR start date should coincide with the first day that the new agency plans to provide LTHH care. The provider should not include dates for acute home health or any lapses in care between the last date of service provided by the previous home health agency and the receiving agency.

The previous provider's PAR end date will be revised to match the information provided in the "last date of service" box, and a new PAR will be entered for the receiving agency.

The Change of Provider letter authorizes Department's fiscal agent to end the current PAR so the new Home Health PAR may be entered. Single Entry Points (SEPs) and Community Centered Boards (CCBs) must include the Case Management Agency's (CMA) identification number on the PAR form.

If the receiving agency is unable to obtain the necessary PAR information from the previous agency, the receiving agency may call the Department's fiscal agent at 1-800-237-0044 to find out whether there is a current Home Health PAR in the system. If a current PAR does exist, the Department's fiscal agent will provide the name and phone number of the Home Health Agency who currently has the approved PAR, but will not be able to provide any of the details for the PAR.

The receiving agency should contact the previous agency, when possible, and notify them that the client is transferring agencies and the effective date of the change. The Change of Provider Form is located on the Department's website (colorado.gov/hcpf)→Providers Services→[Forms](#).

Home Health Agencies should not bill Long-Term Home Health services on another provider's Long-Term Home Health PAR.

Home Health Prior Authorization Information

Medical Assistance Program Home Health is provided on an Acute Home Health basis or Long Term Home Health (LTHH) basis. The Colorado Medical Assistance Program also reimburses Telehealth services for clients who qualify for telehealth monitoring (for more information on Home Health Telehealth services refer to the Home Health Benefit Coverage Standard as referenced in 10 C.C.R 250-10 8.522 – Covered Services).

Acute Home Health: Intermittent Home Health services provided up to 60 consecutive calendar days after an acute onset of an illness, injury or disability, hospitalization or acute onset of exacerbations requiring skilled Home Health care as outlined in the Home Health Benefit Coverage Standard as referenced in 10 C.C.R 2505-10 § 8.522. Covered Services. **Acute Home Health does not require prior authorization.**

- Services Include: Skilled nursing, skilled certified nurse aide, physical therapy, occupational therapy, speech therapy and telehealth services.
- If the client is enrolled in a Medicaid [managed care organization](#) health plan, such as Denver Health, Rocky Mountain Health Plans or Colorado Access Health Plan, the provider will need to contact the MCO directly to determine the MCO acute Home Health prior authorization requirements.

Long Term Home Health: Intermittent Home Health services required for the care of chronic long-term conditions, and/or on-going care that exceeds the acute HH period (61st calendar day of Home Health service). **All Long-Term Home Health services must be prior authorization request.**


- Services Include: Skilled nursing, skilled certified nurse aide, telehealth services.
 - Pediatric clients may also receive physical therapy, occupational therapy and speech therapy.

If a client experiences a new acute event that would warrant acute Home Health service, the agency may move the client to acute care, when:

- At least ten (10) calendar days has elapsed since the client's last acute Home Health episode; **and**
- There is new onset of illness, injury or disability or when the client experiences an acute change in condition from the client's past acute HH episode(s).

Providers should refer to the Code of Colorado Regulations, Program Rules (10 C.C.R. 2505-10), for specific information when providing Home Health care.

PAR Form

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING							
Medical Assistance Program Prior Authorization							
		Adult Long Term Home Health				PA Number being revised:	
				Revision? <input type="checkbox"/> Yes <input type="checkbox"/> No			
1. CLIENT NAME		2. CLIENT ID		3. BIRTHDATE		4. HCBS ELIGIBLE	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. REQUESTING PROVIDER #		6. REQUESTING AGENCY		7. CASE MANAGEMENT AGENCY #		8. DATES COVERED	
						From: Through:	
STATEMENT OF REQUESTED SERVICES							
9. Revenue Code/ Description	10. Specify Frequency	11. # Units	12. Cost Per Unit	13. Total \$ Requested	14. Total Units Authorized	15. PAR Determination	16. Comments
551 RN/LPN			\$103.11				
590 Uncomplicated Nursing Visit, 1			\$72.18				
599 Uncomplicated Nursing Visit, 2+			\$50.52				
571 Certified Nursing Assistant (CNA), Basic			\$36.67				
579 Certified Nursing Assistant (CNA), Extended			\$10.97				
A							
B							
C							
D							
E							
F							
G							
H							
17. TOTAL REQUESTED ADULT LONG TERM HOME HEALTH EXPENDITURES (SUM OF AMOUNTS IN COLUMN 13 ABOVE)						\$0.00	
18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)							
19. ADDITIONAL INFORMATION:							
CASE MANAGER USE							
20. CASE MANAGER NAME		21. AGENCY		22. PHONE #		23. EMAIL	

PAR Form Instructions

Complete this form for Prior Authorization Requests for Adult Long Term Home Health. Submit the PAR per the instructions listed at the bottom. Please include the Plan of Care and other supporting documentation.

For PAR Revisions:

Complete the **Revision** section at the top of the form only if revising a current approved PAR. The number of units should equal more/less the number of units planned for use during the PAR period. The number of units being requested needs to be added to the original number of units approved and include all services that were approved on the original PAR. Use one of the eight (8) lettered (A-H) dropdown fields found in the first few lines immediately following the last code in Column 9, the "Description" column when a Revision requires:

- 1) Additional lines of existing codes to indicate varying rates, units, etc.;
- 2) The inclusion of codes for a timeframe that used codes not listed on the existing form;
- 3) Change of Provider.

Complete the following required fields:

1. **Client Name:** Enter the client's name.
2. **Client ID:** Enter the client's Medical Assistance Program ID number.
3. **Birthdate:** Enter the client's date of birth.
HCBS Eligible: Check "yes," if client is currently enrolled in a waiver program. Check "no," if client is not currently enrolled in a waiver program or is on the wait-list for a waiver program (HCPF or DD).
5. **Requesting Provider #:** Enter the requesting provider's Medical Assistance Program provider number.
6. **Requesting Agency:** Enter requesting home health agency.
7. **Case Management Agency #:** Enter the Case Management Agency number.
8. **Dates Covered (From and Through):** Enter the PAR start date and PAR end date.
9. **Description:** List of approved procedure codes.
10. **Specify Frequency:** Enter visit frequency for home health service requested using daily/weekly, etc.
11. **# Units:** Enter the number of units next to the services for which reimbursement is being requested.
12. **Cost Per Unit:** Cost per unit automatically populates.
13. **Total \$ Requested:** The total dollar amount requested for the service automatically populates.
14. **Total Units Authorized:** The Authorizing entity enters the total number of a units approved per the line.
15. **PAR Determination:** This box is completed by the designated review agency. Select the appropriate determination. Approved (A), Partially Approved (PA), Denied (D)
Comments - Optional: Enter any additional useful information. For PAR revisions this is a required field and should include if a service is authorized for different dates than in Box 8, please include the procedure code and date span here.
17. **Total Requested Expenditures:** Total automatically populates.
18. **Number of Days Covered:** The number of days covered automatically populates.

- Additional Information - Optional:** Home Health Agencies may use this field to explain the reasons for requested frequency, duration, medical necessity, or by CMA to explain reasons for denial or approval of a reduced amount, as needed.
19. **Additional Information - Optional:** Home Health Agencies may use this field to explain the reasons for requested frequency, duration, medical necessity, or by CMA to explain reasons for denial or approval of a reduced amount, as needed.
 20. **Case Manager Name:** Enter the name of the Case Manager.
 - 20A. **Case Manager Signature:** Case Manager signature.
 21. **Agency:** Enter the name of the agency.
 22. **Phone #:** Enter the phone number of the Case Manager.
 23. **Email:** Enter the email address of the Case Manager.
 24. **Date:** Enter the date completed.

"DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY". This is for Department use only.

Send only **New** and **Revised** PARs to:
 Adult with DHS Waivers (DD, DHSS, SLS) --> CCB
 Adult with or without HCPF Waivers (BI, CMHS, EBD, PLWA, SCI) --> CMA/SEP

Note: If submitted to the Department's Fiscal Agent, the following correspondence will not be returned to case managers, outreach will not be performed to fulfill the requests, and all such requests will be recycled: 1) Paper PAR forms that do not clearly identify the case management agency or have incorrect client information in the event the form(s) need to be returned and/or 2) PAR revision requests not submitted on Department approved PAR forms, including typed letters with revision instructions. Should questions arise about what Fiscal Agent staff can process, please contact the Home Health Policy Specialist.

Revenue Coding

The following table identifies the only valid revenue codes for billing Home Health services to the Colorado Medical Assistance Program. Valid revenue codes are not always a Colorado Medical Assistance Program benefit. When valid non-benefit revenue codes are used, the claim must be completed according to the billing instructions for non-covered charges. Home Health providers billing on the UB-04 claim form for services provided to authorized clients must use the appropriate condition code in form locators 18 through 28 (Condition Codes) and use the revenue codes listed below. Claims submitted with revenue codes that are not listed below are denied.

Home Health Revenue Codes

Service Type	Revenue Code		Unit Value
	Acute Home Health	Long Term Home Health	
Supplies (General)	270		Non-covered benefit (Non-covered charges must be shown in <u>both</u> FL 47 and 48 of the claim form)
RN/LPN Standard Visit	550	551	One visit (not to exceed 2 ½ hours)
Uncomplicated Nursing (Visit 1)	n/a	590	One Visit
Uncomplicated Nursing Visit (Visit 2+)	n/a	599	One Visit

Service Type	Revenue Code		Unit Value
	Acute Home Health	Long Term Home Health	
HHA BASIC	570	571	One hour
HHA Extended	572	579	For visits lasting more than one hour, extended units of 15-30 minutes
PT	420	421 (pediatric LTHH only)	One Visit (not to exceed 2 ½ hours)
OT	430	431 (pediatric LTHH only)	One visit (not to exceed 2 ½ hours)
S/LT	440	441 (pediatric LTHH only)	One visit (not to exceed 2 ½ hours)
Home health Telehealth Set-up Fee	583 TG 98969 (proc)	780 TG 98969 (proc)	Installation and client education of telehealth equipment (1 time only)
Home health Telehealth Daily Monitoring	583 98969 (proc)	780 98969 (proc)	One unit per day that telehealth monitoring is obtained (limit 31 units/month)

Reimbursable Home Health Services

The licensed and certified Class A Home Care shall not utilize staff that has been excluded from participation in federally funded health care programs by the US Department of Health and Human Services (HHS)/Office of Inspector General (OIG) and shall be in good standing with the Colorado Department of Regulatory Agencies (DORA) or other regulatory agency:

Registered Nurses (RN) and Licensed Practical Nurses (LPN) must have a current, active license in accordance with the DORA Colorado Nurse Practice Act at §12-38-111, C.R.S..

- Acute Home Health: All nursing services provided during the acute Home Health period shall be billed under revenue code 550. **No PAR is required.**
- Long-Term Home Health: Nursing services provided during Long-Term Home Health shall be billed using the appropriate revenue codes based on the purpose and complexity of the nursing visit. Standard, infrequent or complicated nursing visits may be billed using revenue code 551. Nursing visits that are uncomplicated in nature or visits that are uncomplicated with frequent revisits completed by the nurse shall be billed using revenue codes 590 and 599).
 - Long-Term Home Health nursing visits for the **sole** purpose of assessing a client may be reimbursed for a limited time when managing, and reporting to the client's physician on specific conditions and/or symptoms which are not stable.

Certified Nurse Aides (CNA) must have a current, active license in accordance with the DORA Colorado Nurse Aide Practice Act at §12-38-111, C.R.S..

- Acute Home Health: Skilled certified nurse aide visits are reimbursed based on the amount of time the CNA is providing skilled care to a client. If a certified nurse aide provides care for at least 15

minutes but not more than 60 minutes, the agency shall bill a basic unit with revenue code 570. For each every additional 30 minutes the certified nurse aide provides hands-on assistance to the client the agency may bill an extended CNA unit with revenue code 572. A unit of time that is less than 15 minutes shall not be reimbursable as a basic unit and at least 15 minutes must elapse before an agency may bill an extended unit. **No PAR is required.**

- Long-Term Home Health: Skilled certified nurse aide visits are reimbursed based on the amount of time the CNA is providing skilled care to a client. If a certified nurse aide care for at least 15 minutes but not more than 60 minutes, the agency shall bill a basic unit with revenue code 571. For each every additional 30 minutes the certified nurse aide provides hands-on assistance to the client the agency may bill an extended CNA unit with revenue code 579. A unit of time that is less than 15 minutes shall not be reimbursable as a basic unit and at least 15 minutes must elapse before an agency may bill an extended unit.

Physical Therapists (PT) must have a current, active license in accordance with the Colorado Physical Therapy Practice Act at §12-41-107, C.R.S.

- Acute Home Health: All physical therapy services may be provided on pediatric and adult Home Health client and are billed using revenue code 420 on a per visit basis. **No PAR is required.**
- Long-Term Home Health: Physical therapy is available to pediatric clients when prior authorized and deemed medically necessary. Physical therapy is reimbursed on a per visit basis using revenue code 421.

Occupational Therapists (OT) must have a current, active registration in accordance with the DORA Colorado Occupational Therapy Practice Act at §12-40.5-106, C.R.S.

- Acute Home Health: All occupational therapy services may be provided to all Medicaid Home Health clients with a demonstrated need for speech therapy interventions. Occupational therapy services are reimbursed on per visit basis using revenue code 430. **No PAR is required.**
- Long-Term Home Health: Occupational therapy is available to pediatric clients when prior authorized and deemed medically necessary. All Home Health speech therapy is reimbursed on a per visit basis using revenue code 431.

Speech/Language Pathologists (SLP) who have a current, active certification from the American Speech-Language-Hearing Association (ASHA).

- Acute Home Health: All speech therapy services may be provided to all Medicaid Home Health clients with a demonstrated need for speech therapy interventions. Speech therapy services are reimbursed on per visit basis using revenue code 440. **No PAR is required.**
- Long-Term Home Health: Speech therapy is available to pediatric clients when prior authorized and deemed medically necessary. All Home Health speech therapy is reimbursed on a per visit basis using revenue code 441.

Telehealth Services include the installation and on-going remote monitoring of clinical data through technologic equipment in order to detect minute changes in the client's clinical status that will allow Home Health agencies to intercede before a chronic illness exacerbates requiring emergency intervention or inpatient hospitalization.

- Acute Home Health: Agencies are reimbursed for the initial installation and education of telehealth monitoring equipment by billing revenue code 583 with the procedure code 98969. This initial

charge shall only be billed once per client per agency. The agency may bill for every day they receive and review the client's clinical information by billing revenue code 583 along with procedure code 98969 and the modifier 'TG.' **No PAR is required prior to billing for acute telehealth services, but agencies should notify the Department or its designee when a client is enrolled in the service.**

- Long-Term Home Health: Agencies are reimbursed for the initial installation and education of telehealth monitoring equipment by billing revenue code 780 with the procedure code 98969. This initial charge shall only be billed once per client per agency. The agency may bill for every day they receive and review the client's clinical information by billing revenue code 780 along with procedure code 98969 and the modifier 'TG.' **No PAR is required prior to billing for acute telehealth services, but agencies should notify the Department or its designee when a client is enrolled in the service.**

Non-Reimbursable Home Health Services

- Supplies used for routine Home Health are not reimbursed separately through the Home Health or Durable Medical Equipment (DME) benefit. Non-routine or client specific supplies must be reimbursed through the client's DME benefit.
- Nursing Visits for purpose of psychiatric counseling
- Certified nurse aide visits for the purpose of providing **only** unskilled personal care and/or homemaking services.
- Nursing or CNA visits provided in a shift (visits lasting more than 4½ consecutive hours)
- Nursing visits for the **sole** purpose of providing supervision of the CNA or other Home Health staff
- Nursing visits for the **sole** purpose of completing the Home Health plan of care/recertification
- Long-Term Home Health nursing visits for the **sole** purpose of teaching the client or their family member
- Long-Term Home Health nursing visits for the **sole** purpose of assessing a stable client where management, and reporting to physician of specific conditions and/or symptoms which are not stable

Special Reimbursement Conditions for Home Health Services

- Acute Home Health services provided to Medicaid MCO clients shall be prior authorized (if required) and reimbursed under Medicaid MCO rules.
- If a client is eligible for Medicare and Medicaid, Medicare is always the first payer when a client has skilled Home Health needs and the client is unable to leave their residence for non-medical programs and treatments (Homebound). **All Medicare requirements shall be met and exhausted prior to billing Medicaid for Home Health services, except when:**
 - Medication box pre-filling is the only service provided;
 - Certified Home Health Aide Services are the only services provided;
 - Occupational Therapy Services when provided as the sole skilled service;
 - Routine Laboratory Draw Services are the only service provided;
 - If the client is (1) stable, (2) not experiencing an acute episode, and (3) routinely leaves the home unassisted for social, recreational, educational and/or employment purposes (not Homebound)
 - Medicare & Medicaid may be billed simultaneously, if Medicare deems that the client is homebound based on the documentation provided the all Medicaid funds shall be repaid to Medicaid.

- Any combination of a through e above.
- The record contains clear and concise documentation describing any exceptions.
- Home Health services provided to clients who are eligible for both Medicare & Medicaid or have another third party insurance & Medicaid must be billed to Medicare first. All insurance requirements must be met and exhausted prior to billing Home Health services to Medicaid.
 - A denial must be kept in the client's record and updated annually on the anniversary of the denial.
 - The third party insurance denials must be based on non-coverage and not due to the failure of adhering to the requirements set forth by the insurance agency.
 - Medicaid will not accept a "no-pay" denial (type of bill 320, condition code 21) from Medicare as a valid denial of Medicare coverage.
- The Home Health Agency must maintain a signed Advance Beneficiary Notice (ABN) that is completed as prescribed by Medicare.

Reimbursable Home Health Service Locations

The Home Health program reimburses for skilled nursing, skilled certified nurse aide, physical therapy, occupational therapy, and speech therapy services that are provided on an intermittent or per visit basis to Colorado Medical Assistance Program clients in their place of residence.

Colorado Medical Assistance Program pediatric clients may receive Home Health services outside of their place of residence when:

- The Home Health services can be provided safely and adequately in a location other than the client's residence;
- Home Health service and interventions will be at least equally effective in a location other than the client's residence;
- It is clinically appropriate for the Home Health services to be provided in a location other than the client's residence;
- It is not primarily for the convenience of the client, client's family, physician or other care provider;
- It is not provided in a group home, nursing facility, hospital or other facility; and
- It is not provided on public school grounds or as a part of an Individualized Education Program.

Other Billing Information:

- The Colorado Medical Assistance Program will reimburse two Home Health staff to care for a client when it is necessary to safely provide client care due to complexity of tasks, client weight, etc. and when it has been prior authorized.
- Client's Home Health Medical records must be retained by the agency for at least six (6) years unless State or Medicaid regulations require that the client's records be maintained for more than six (6) years.

Paper Claim Reference Table

The information in the following table provides instructions for completing form locators as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual*. Unless otherwise noted,

all data form locators on the UB-04 have the same attributes (specifications) for the Colorado Medical Assistance Program as those indicated in the *NUBCUB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each form locator **may not** be used for submitting paper claims to the Colorado Medical Assistance Program. The appropriate code values listed in this manual must be used when billing the Colorado Medical Assistance Program.

The UB-04 Certification document (located after the Late Bill Override Date instructions and in the Provider Services [Forms](#) section) must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A in the Appendices of the Provider Services [Billing Manuals](#) section.

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page, may be submitted through the Web Portal.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to the Colorado Medical Assistance Program for home health claims.

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	<p>Required</p> <p>Enter the provider or agency name and complete mailing address of the provider who is billing for the services:</p> <p style="padding-left: 40px;">Street/Post Office box City State Zip Code</p> <p>Abbreviate the state in the address to the standard post office abbreviations. Enter the telephone number.</p>
2. Pay-to Name, Address, City, State	Text	<p>Required only if different from FL 1.</p> <p>Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services:</p> <p style="padding-left: 40px;">Street/Post Office box City State Zip Code</p> <p>Abbreviate the state in the address to the standard post office abbreviations.</p>
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	<p>Optional</p> <p>Enter information that identifies the client or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.</p>
3b. Medical Record Number	17 digits	<p>Optional</p> <p>Enter the number assigned to the patient to assist in retrieval of medical records.</p>

Form Locator and Label	Completion Format	Instructions																		
4. Type of Bill	3 digits	<p>Required</p> <p>Home Health/Hospice</p> <p>Use the following code range for Home Health/Hospice:</p> <p>33X for Home Health/Private Duty Nursing services</p> <p>Use 321-324 or 341-344 for Medicare crossover claims.</p> <p>Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <table><tr><td><u>Digit 1</u></td><td><u>Type of Facility</u></td></tr><tr><td>1</td><td>Hospital</td></tr><tr><td>2</td><td>Skilled Nursing Facility</td></tr><tr><td>3</td><td>Home Health</td></tr><tr><td>4</td><td>Religious Non-Medical Health Care Institution Hospital Inpatient</td></tr><tr><td>5</td><td>Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services</td></tr><tr><td>6</td><td>Intermediate Care</td></tr><tr><td>7</td><td>Clinic (Rural Health/FQHC/Dialysis Center)</td></tr><tr><td>8</td><td>Special Facility (Hospice, RTCs)</td></tr></table>	<u>Digit 1</u>	<u>Type of Facility</u>	1	Hospital	2	Skilled Nursing Facility	3	Home Health	4	Religious Non-Medical Health Care Institution Hospital Inpatient	5	Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services	6	Intermediate Care	7	Clinic (Rural Health/FQHC/Dialysis Center)	8	Special Facility (Hospice, RTCs)
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Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	<div data-bbox="800 268 1365 1010"> <u>Digit 2</u> <u>Bill Classification (Except clinics & special facilities):</u> 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other </div> <div data-bbox="800 1035 1317 1528"> <u>Digit 2</u> <u>Bill Classification (Clinics Only):</u> 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (COFRs) 6 Community Mental Health Center </div> <div data-bbox="800 1554 1357 1934"> <u>Digit 2</u> <u>Bill Classification (Special Facilities Only):</u> 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility </div>

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	<p><u>Digit</u> <u>Frequency:</u></p> <p><u>3</u></p> <p>0 Non-Payment/Zero Claim</p> <p>1 Admit through discharge claim</p> <p>2 Interim - First claim</p> <p>3 Interim - Continuous claim</p> <p>4 Interim - Last claim</p> <p>7 Replacement of prior claim</p> <p>8 Void of prior claim</p>
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period — From/Through	<p>From: 6 digits MMDDYY</p> <p>Through: 6 digits MMDDYY</p>	<p>Required</p> <p>Home Health-Private Duty Nursing/Hospice</p> <p>"From" date is the actual start date of services.</p> <p>"From" date cannot be prior to the start date reported on the initial prior authorization, if applicable, or is the first date of an interim bill.</p> <p>"Through" date is the actual discharge date, or final date of an interim bill.</p> <p>"From" and "Through" dates cannot exceed a calendar month (e.g., bill 01/15/10 thru 01/31/10 and 02/01/10 thru 02/15/10, not 01/15/10 thru 02/15/10).</p> <p>Match dates to the prior authorization if applicable.</p> <p>If patient is admitted and discharged the same date, that date must appear in both fields.</p> <p>Detail dates of service must be within the "Statement Covers Period" dates.</p>
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	<p>Required</p> <p>Enter the client's last name, first name and middle initial.</p>

Form Locator and Label	Completion Format	Instructions
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the client's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the client's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the client's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the client's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Text	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the client's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012009 for January 1, 2009.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the client's sex.
12. Admission Date	6 digits	Required Home Health/Hospice Enter the date care originally started from any funding source (e.g., Medicare, Colorado Medical Assistance Program, Third Party Resource, etc.).
13. Admission Hour		Not Required
14. Admission Type		Not Required

Form Locator and Label	Completion Format	Instructions
15. Source of Admission		Not Required
16. Discharge Hour		Not Required
17. Patient Discharge Status	2 digits	<p>Required</p> <p>Home Health/Hospice</p> <p>Enter client status as ongoing patient (code 30) or as of discharge date. Agencies are limited to the following codes:</p> <ul style="list-style-type: none"> 01 Discharged to Home 03 Discharged/Transferred to SNF 04 Discharged/Transferred to ICF 05 Discharged/Transferred to Another Type of Institution 06 Discharged/Transferred to organized Home Health Care Program (HCBS) 07 Left Against Medical Advice 20 Expired (Deceased - Not for Hospice use) 30 Still patient (ongoing) 40 Expired at home 41 Expired in hospital, SNF, ICF, or free-standing hospice 42 Expired - place unknown 50 Hospice - Home 51 Hospice - Medical Facility
18-28. Condition Codes	2 Digits	<p>Conditional</p> <p>Use condition code A1 to bill PDN hours greater than 16 for children</p>
29. Accident State		Optional
31-34. Occurrence Code/Date	2 digits and 6 digits	<p>Required</p> <p>Use occurrence code 27 and enter the Plan of Care start date.</p> <p>Enter the date using MMDDYY format.</p>

Form Locator and Label	Completion Format	Instructions
35-36. Occurrence Span Code From/ Through	None	Leave Blank
38. Responsible Party Name/ Address	None	Leave blank

Form Locator and Label	Completion Format	Instructions
39-41. Value Code and Amount	2 characters and 9 digits	<p>Conditional</p> <p>Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim.</p> <p>Never enter negative amounts. Fields and codes must be in ascending order.</p> <p>If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered.</p> <ul style="list-style-type: none"> 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days <p>Enter the amount paid by indicated payer:</p> <ul style="list-style-type: none"> A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C <p>For Rancho Coma Score bill with appropriate diagnosis for head injury.</p>

Form Locator and Label	Completion Format	Instructions
42. Revenue Code	3 digits	<p>Required</p> <p>Enter the revenue code that identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order.</p> <p>A <u>revenue code</u> must appear only <u>once</u> per date of <u>service</u>. If more than one of the same service is provided on the same day, combine the <u>units</u> and charges on one line accordingly.</p> <p>Home Health</p> <p>Enter the appropriate Revenue code. <i>Home health services cannot be provided to Nursing Facility residents.</i></p>
43. Revenue Code Description	Text	<p>Required</p> <p>Enter the revenue code description or abbreviated description.</p>
44. HCPCS/Rates/HIPPS Rate Codes	5 digits	<p>Required for the following:</p> <ul style="list-style-type: none"> Home Health RN visit: Use only HCPCS code T1000 with modifier TD for revenue code 552. Home Health LPN visit: Use only HCPCS code T1000 with modifier TE for revenue code 559. Home Health private duty nursing RN group visit: Use only HCPCS code T1000 with modifiers HQ and TD for revenue code 580. Home Health private duty nursing LPN group visit: Use only HCPCS code T1000 with modifiers HQ and TE for revenue code 582. <p>When billing HCPCS codes, the appropriate revenue code must also be billed.</p>
45. Service Date	6 digits	<p>Required</p> <p>Enter the date of service using MMDDYY format for each detail line completed.</p>
46. Service Units	3 digits	<p>Required</p> <p>Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)</p>

Form Locator and Label	Completion Format	Instructions
47. Total Charges	9 digits	<p>Required</p> <p>Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts.</p> <p>A grand total in line 23 is required for all charges.</p>
48. Non-Covered Charges	Up to 9 digits	<p>Conditional</p> <p>Enter incurred charges that are not payable by the Colorado Medical Assistance Program.</p> <p>Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.)</p> <p>Each column requires a grand total.</p>
50. Payer Name	1 letter and text	<p>Required</p> <p>Enter the payment source code followed by name of each payer organization from which the provider might expect payment.</p> <p>At least one line must indicate The Colorado Medical Assistance Program.</p> <p>Source Payment Codes</p> <ul style="list-style-type: none"> B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other <p>Line A Primary Payer</p> <p>Line B Secondary Payer</p> <p>Line C Tertiary Payer</p>

Form Locator and Label	Completion Format	Instructions
51. Health Plan ID	8 digits	<p>Required</p> <p>Enter the provider's Health Plan ID for each payer name.</p> <p>Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider. Payment is made to the enrolled provider or agency that is assigned this number.</p>
52. Release of Information	N/A	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	N/A	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	<p>Conditional</p> <p>Complete when there are Medicare or third party payments.</p> <p>Enter third party and/or Medicare payments.</p>
55. Estimated Amount Due	Up to 9 digits	<p>Conditional</p> <p>Complete when there are Medicare or third party payments.</p> <p>Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amounts.</p> <p>Medicare Crossovers</p> <p>Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability amounts.</p>
56. National Provider Identifier (NPI)	10 digits	<p>Optional</p> <p>Enter the billing provider's 10-digit National Provider Identifier (NPI).</p>
57. Other Provider ID		<p>Optional</p> <p>Submitted information is not entered into the claim processing system.</p>
58. Insured's Name	Up to 30 characters	<p>Required</p> <p>Enter the client's name on the Colorado Medical Assistance Program line.</p>

Form Locator and Label	Completion Format	Instructions
58. Insured's Name (continued)	Up to 30 characters	Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization. Include letter prefixes or suffixes.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is covered.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this field, if a PAR is required and has been approved for services.
64. Document Control Number		Optional Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)

Form Locator and Label	Completion Format	Instructions
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	6 digits	Not Required Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Submitted information is not entered into the claim processing system.
71. PPS Code		Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	N/A	Not Required
74A. Other Procedure Code/Date	N/A	Not Required

Form Locator and Label	Completion Format	Instructions
76. Attending NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Required	10 digits 8 digits 8 digits	NPI - Enter the 10-digit NPI assigned to the physician having primary responsibility for the patient's medical care and treatment. QUAL – Enter "1D" for Medicaid followed by the provider's eight-digit Colorado Medical Assistance Program provider ID. Medicaid ID - Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment.
76. Attending (continued) Attending- Last/First Name	Text	Numbers are obtained from the physician, and <u>cannot</u> be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the client leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating-NPI/QUAL/ID		Optional Submitted information is not entered into the claim processing system.
78-79. Other ID NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Conditional	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Conditional Complete when attending physician is not the PCP or to identify additional physicians. Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the primary care physician (PCP) or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number in FL 78. The name of the Colorado Medical Assistance Program client's PCP appears on the eligibility verification. The Colorado Medical Assistance Program does not require that the primary care physician number appear more than once on each claim submitted. The "other" physician's last and first names are optional.

Form Locator and Label	Completion Format	Instructions
80. Remarks	Text	Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

- 1 Proof of Eligibility Unknown or Unavailable
- 3 Authorization Delays
- 7 Third Party Processing Delay
- 8 Delay in Eligibility Determination
- 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 11 Other



The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services [Billing Manuals](#) section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to a fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>Colorado 1500</i>: Indicate "LBOD" and the date in box 30 - Remarks. ➤ <i>2006 ADA Dental</i>: Indicate "LBOD" and the date in box 35 - Remarks.
Adjusting Paid Claims	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p>

Billing Instruction Detail	Instructions
	<p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>
Denied Paper Claims	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p> <p>Correct the claim errors and refile within 60 days of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
Returned Paper Claims	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p>Correct the claim errors and re-file within 60 days of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
Rejected Electronic Claims	<p>An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.</p> <p>Correct claim errors and refile within 60 days of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p>LBOD = the date shown on the claim rejection report.</p>
Denied/Rejected Due to Client Eligibility	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p>File the claim within 60 days of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the client and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
Retroactive Client Eligibility	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p>

Billing Instruction Detail	Instructions
	<p>File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> Identifies the patient by name States that eligibility was backdated or retroactive Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>
Delayed Notification of Eligibility	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage.</p>
Delayed Notification of Eligibility	<p>Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H in the Appendices in the Provider Services Billing Manuals section of the Department's Web site) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> Claims must be filed within 365 days of the date of service. No exceptions are allowed. This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
Electronic Medicare Crossover Claims	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
Medicare Denied Services	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p>

Billing Instruction Detail	Instructions
	<p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>

Commercial Insurance Processing	<p>The claim has been paid or denied by commercial insurance.</p> <p>File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p>LBOD = the date commercial insurance paid or denied.</p>
Correspondence LBOD Authorization	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific client, claim, services, or circumstances.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
Client Changes Providers during Obstetrical Care	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p>File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.</p> <p>LBOD = the last date of OB care by the billing provider.</p>

Colorado Medical Assistance Program

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ *Date:* _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Home Health Claim Example

1 Home Health Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333										2										3a PAT. CNTL # b MED. REC. #										4 TYPE OF BILL 333																																																																																																																																																															
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UB-04 CMS-1450
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OMB APPROVAL PENDING

NUBC[®] National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

F245-367-000

[illegible]

F245-367-000

Revised: 09/15

HH & PDN Revisions Log

Revision Date	Additions/ Changes	Pages	Made by
02/13/2008	Electronic Claims – Updated first two paragraphs with bullets	1	pr-z
04/24/2008	PARs – Added additional Information about submission within 10-days	4	jg
04/24/2008	Updated new name for DDM and corrected address for CFMC	7	jg
11/05/2008	Updated web addresses	Throughout	jg
03/29/2009	General Updates	Throughout	jg
01/18/2010	Updated Web site links	Throughout	jg
02/17/2010	Changed EOMB to SPR	25	jg
03/04/2010	Added link to Program Rules	1	jg
08/31/2011	Changed wording from authorizing agent to authorizing agency. Deleted CFMC, added ColoradoPAR address and fax number	4,7 7	crc
09/21/2011	Added TOC Accepted changes Created new claim examples	1 Throughout 29-31	Jg
12/06/2011	Replaced 997 with 999 Replaced wpc-edi.com/hipaa with wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3)	4 3 3	ss
07/20/2012	Removed PAR Instructional Reference Removed old PAR form Added new PAR form and Completion Instructions Updated TOC	5-8 9 6 & 7 1	jg
08/27/2012	Updated flowchart	7	jg
05/14/2013	Updated policy information per SME	2-24	Cc
09/30/2015	Swapped out old state seal Replaced ICD-9 with ICD-10 mentions and updated claim images.	31 Throughout	JH
10/06/2015	Updated CWQI information for eQSuite®	Throughout	JH
1/20/2015	Converted font to Tahoma	Throughout	JH

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.